Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Edward F Wolski M.D./Wol+Med 2436 I-35 East, South, STE. 336 Denton, Texas 76205	MFDR Tracking #: M4-07-5938-01 (previously M4-05-2620-01) DWC Injured E Date
Respondent Name and Box #: Commerce & Industry Insurance Rep. Box #: 19	Employ Insurance Car

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Dates of service 2/18/04 through 3/2/04 are claims for our CARF accredited Work Hardening program. These dates were pre-authorized. The carrier paid for the other dates of Work Hardening. All of the claims that were denied with "R" were diagnosed with the compensable body area, Lumbar."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $3,691.26*
3. CMS 1500s
4. EOBs
5. Copy of Contested Case Hearing (CCH) Decision and Order

Sent
JAN 15 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

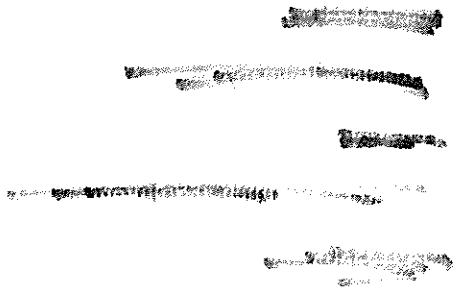
Respondent's Position Summary: "The provider claims to have provided treatment for a body part that the carrier has not accepted..."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
12/03/03	20550 x 4 units	U849, E560	1, 4, 11	**$233.45**
02/18/04, 02/20/04, 02/23/04 02/26/04, 02/27/04, 03/02/04	97545 x 6 units	R	2, 3, 6, 10	**$768.00**
02/18/04, 02/20/04, 02/23/04, 02/26/04, 02/27/04, 03/02/04	97546 x 36 units	R	2, 3, 7, 10	**$2,304.00**
03/17/04	20550 x 4 units	R	2, 3, 5, 10	**$270.36**
03/31/04	99214	R	2, 3, 8, 10	**$96.91**
03/31/04	99080-73	R	2, 3, 9	**$15.00**
Total Due:				**$3,687.72**



PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

* In an email dated 10/23/07, Requestor has withdrawn CPT coding 64999 with disputed amount of $255.00 on DOS 03/17/04 and CPT coding A4595 with disputed amount of $72.02 on DOS 03/12/04. An earlier 10/08/07 updated Table of Disputed Services was emailed removing DOS 01/19/04 for CPT code 20550 for $237.00 in dispute. This totals $564.02 removed from original Table of Disputed Services total of $4,255.28.

1. These services were partially reimbursed the amount of $33.35 by the Respondent with reason code "U849 – This multiple procedure was reduced 50% according to the fee schedule or usual and customary guidelines and "E560 – The charge for this procedure exceeds the fee schedule or usual and customary allowance." The code is not subject to multiple procedure rules.
2. These services were denied by the Requestor with reason code "R – The service(s) is for a condition(s) which is not related to the covered work related injury."
3. Per CCH decision dated 11/29/05, "The compensable injury of November 20, 2003 extends to and includes lumbar disc disease and a herniation at L5-S1." The Requestor has billed with diagnoses codes 722.10 – displacement lumbar intravert disc w/o myelopath, 724.2 – lumbago, and 722.2 displacement intervert disc site uns w/o myelopa. Therefore, the Requestor has billed the compensable body part. The CCH order shows, "Carrier is ordered to pay benefits in accordance with this decision, The Texas Workers' Compensation Act, and Commissioner's Rules." Reimbursement is recommended.
4. On DOS 12/0/03 CPT code 20550 has a MAR of $66.70 ($53.36 x 125%) x 4 units = $266.80. Respondent has reimbursed $33.35 previously, therefore an additional amount of **$233.45** is due per Rule 134.202.
5. On DOS 03/17/04 CPT code 20550 has a MAR of $54.07 x 125% x 4 (four) units totaling $270.40. Per Rule 134.202(d), Requestor is disputing the amount of $270.36 which is less than MAR, therefore **$270.36** is recommended for reimbursement.
6. CPT code 97545-WH-CA has a MAR of $64.00 per hour for 6 (six) DOS. The CPT code 97545 represents 2 (two) hours each , therefore $64.00 x 2 (two) hours x 6 (six) DOS = **$768.00** due to Requestor per Rule 134.202.
7. CPT code 97546-WH-CA has a MAR of $64.00 per hour for 6 (six) hours x 6 (six) DOS = **$2,304.00** due to Requestor per Rule 134.202.
8. CPT code 99214 has a MAR of $77.53 x 125% totaling the amount of **$96.91** recommended to Requestor for reimbursement per Rule 134.202.
9. CPT code 99080-73 has a DWC MAR of **$15.00** and is the amount recommended for reimbursement to Requestor per Rule 129.5.
10. Per review of Box 32 on CMS-1500, zip code 76205 is located in Denton County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

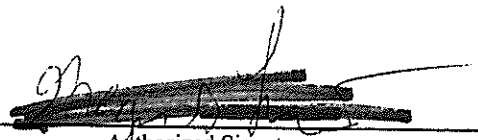
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $3,687.72 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:



Authorized Signature

Medical Fee Dispute Resolution Officer

01/14/08
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.